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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JENNIFER PAIGE KLINE, a.k.a. JENNIFER P. ROHN, a.k.a. JENNIFER ROHN SOVOHN, a.k.a. JENNIFER HUTCHINS** **543 Cassatt Way** **San Jose, CA 95125** **Registered Nurse License No. 691632** Respondent.	Case No. 2012-15 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about October 30, 2006, the Board of Registered Nursing issued Registered Nurse License Number 691632 to Jennifer Paige Kline, also known as Jennifer P. Rohn, also known as Jennifer Rohn Sovohn, also known as Jennifer Hutchins (Respondent). The Registered Nurse License expired on July 31, 2010, and has not been renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

6. Section 118, subdivision (b), of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY PROVISIONS

7. Section 2761 of the Code states, in pertinent part:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

8. Section 2762 of the Code states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

CONTROLLED SUBSTANCES/DANGEROUS DRUGS

9. Code section 4021 states:

"'Controlled substance' means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code."

10. Code section 4022 provides:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

"(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only' or words of similar import.

"(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a _____,' 'Rx only,' or words of similar import . . .

"(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

11. "Ativan" is a brand name for Lorazepam. It is a depressant and a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(16), and a dangerous drug as defined by Code section 4022. It is indicated in the treatment of anxiety with depression or acute alcohol withdrawal symptoms, or both.

12. "Demerol" is a trade name for Pethedine or Meperidine Hydrochloride. It is Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(17), and is a dangerous drug as defined by Code section 4022. Demerol can produce drug

dependence of the Morphine type and therefore has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of Demerol and it should be prescribed and administered with the same degree of caution appropriate to the use of Morphine.

13. "Dilaudid" is a trade name for Hydromorphone. It is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(J), and a dangerous drug as defined by Code section 4022. It is indicated for the treatment of moderate to severe pain.

14. "MS Contin" is the brand name for Morphine Sulfate. It is Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(L), and a dangerous drug as defined by Code section 4022. Morphine is a central nervous system depressant that is used in the management of pain.

COST RECOVERY

15. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTS

16. Respondent was employed as a registered nurse in the Oncology Department at Good Samaritan Hospital (GSH) in San Jose, California from on or about April 2007 until she was terminated on August 27, 2008.

17. On or about August 2, 2008, a doctor at GSH complained about Respondent's aggressive request for additional Hydromorphone for a patient during the night shift on August 1-2, 2008. Following this complaint, the Nursing Operations Officer at GSH, M. Murphy, began an investigation into Respondent's conduct. On or about August 5, 2008, Respondent was issued a "Corrective Action Notice" based upon her failure to document the administration of narcotics that she had removed from AcuDose on July 27, 2008, and July 29, 2008. The AcuDose is a computerized management, storage, and medication dispensing cart that contains all medications

used throughout GSH. Each AcuDose medication cart is linked to the main computer maintained by GSH's Pharmacy Department, which stores all AcuDose information. Medical staff members have access to the AcuDose cart through a unique username and password.

18. On or about August 6, 2008, the Director of GSH's Oncology Department, L. Ankeny, provided Respondent with a "Development Plan" covering the period from August 6, 2008, through April 8, 2009. On this same date, the wife of Patient 2 reported to L. Ankeny that her husband did not receive any pain medication for approximately two hours, and that Respondent had pushed Patient 2's PCA button. PCA stands for "patient-controlled analgesic" and it is an infusion device that allows a patient to self-administer narcotic analgesics within the limits prescribed by the physician. The device delivers solutions intravenously, subcutaneously, or epidurally and allows patient activation by means of a pendant button on a cord connected to the pump or a button directly on the pump. "PCA by Proxy" is a term used to describe when an unauthorized person activates the dosing mechanism of an analgesic infusion pump and thereby delivers analgesic medication to the patient.

19. On or about August 6, 2008, Respondent was suspended from GSH pending further investigation of her nursing practice related to the administration and documentation of narcotics she removed from AcuDose. The Nursing Operations Manager, M. Murphy, conducted a drug audit that included the review of medical records and AcuDose reports for Patients 1 through 7. The audit revealed that Respondent had a pattern of removing from AcuDose much larger quantities of medications for patients in her care compared to other nurses that cared for the same patients before and after Respondent. The audit also revealed that Respondent documented giving patients the maximum amount of pain medications allowed by the physician's orders, and at times the medications were given sooner than at the prescribed intervals. Furthermore, the audit revealed that the intervals between the time Respondent removed narcotics from AcuDose and the time she documented wastes in AcuDose sometimes exceeded 30 to 120 minutes. On or about August 27, 2008, Respondent met with the Director of GSH Employee and Labor Relations and L. Ankeny. After the meeting, Respondent was given a Notice of Discharge/Termination for her mismanagement of narcotics from AcuDose from on or about July 2008 through August

2008. The following are examples of Respondent's above-referenced conduct and her inconsistent and unintelligible entries for controlled substances and dangerous drugs that she removed from AcuDose, as revealed by the audit:

PATIENT 1

a. On or about August 1, 2008, at 10:04 p.m., Respondent removed Dilaudid 1 milligram syringe from AcuDose for Patient 1. Respondent documented on the Medication Administration Record (MAR) that she administered Dilaudid 1 milligram at 9:55 p.m., which occurred before she removed the drug from AcuDose.

b. On or about August 1, 2008, at 11:41 p.m., Respondent removed Dilaudid 1 milligram IV from AcuDose for Patient 1. Respondent documented on the MAR that she administered Dilaudid 1 milligram at 11:31 p.m., which occurred before she removed the drug from AcuDose. Furthermore, the dose was a one-time order and Respondent had previously administered the dose at 10:04 p.m.

c. On or about August 2, 2008, at 3:03 a.m., Respondent removed Dilaudid 2 milligrams syringe from AcuDose for Patient 1. Respondent documented on the MAR administering Dilaudid 1.5 milligrams to Patient 1 at 3:00 a.m., which occurred before she removed the drug from AcuDose. Respondent documented the waste of Dilaudid 0.5 milligrams at 4:22 a.m., approximately 80 minutes after she removed it from AcuDose.

d. On or about August 2, 2008, at 3:51 a.m., Respondent removed Dilaudid 2 milligrams syringe from AcuDose for Patient 1. Respondent documented on the MAR that she administered Dilaudid 1.5 milligrams to Patient 1 at 3:44 a.m., which occurred before she removed the drug from AcuDose. Respondent documented waste of Dilaudid 0.5 milligrams at 4:22 a.m., approximately 30 minutes after she removed it from AcuDose.

PATIENT 2

e. On or about August 5-6, 2008, Respondent was assigned to work the night shift. Respondent was assigned to care for Patient 2. Patient 2 had a physician's order dated August 1, 2008, for Ativan IV 1 milligram every six hours as needed for nausea. Patient 2 also had a physician's order dated August 3, 2008, for a PCA pump. Finally, Patient 2 had a physician's

order dated August 5, 2008, for Dilaudid/Hydromorphone 2 milligrams IV every two hours as needed for breakthrough pain or prior to mouthwash administration.

f. In the three days prior to Respondent's August 5-6, 2008 night shift, Patient 2 required only 2.5 milligrams Dilaudid for breakthrough pain. During Respondent's August 5-6, 2008 shift, Patient 2 required 12 milligrams of Dilaudid, which was a much higher amount than required while other nurses were assigned to the care of Patient 2 both before and after Respondent's August 5-6, 2008 night shift. Patient 2 was not administered any Dilaudid IV after Respondent's August 6, 2008 shift, through August 12, 2008. Furthermore, according to Patient 2's wife, Patient 2 received only one dose of Ativan on August 5, 2008, at approximately 9:00 p.m., and did not receive any other pain medications from Respondent until Respondent pushed Patient 2's PCA button for Dilaudid on August 6, 2008.

PATIENT 3

g. On or about July 25-26, 2008, Respondent was assigned to work the night shift. Respondent was assigned to care for Patient 3. Patient 3 had a physician's order dated July 24, 2008, for Demerol 50 milligrams IM every six hours as needed for pain. Except for the first dose of Demerol administered to Patient 3 upon Patient 3's arrival to Oncology, Respondent administered all other doses of Demerol to Patient 3 from July 25-26, 2008.

h. On or about July 25, 2008, at 5:32 a.m., Respondent removed Demerol 100 milligrams from AcuDose for Patient 3. Respondent documented on the MAR at 5:23 a.m. that the drug was not administered because the patient refused the medication. Respondent's documentation in the MAR was made before she removed the Demerol from AcuDose. Respondent documented waste of the Demerol at 5:58 a.m., almost 30 minutes after removing it from AcuDose.

i. On or about July 25, 2008, at 8:29 p.m., Respondent removed Demerol 100 milligrams syringe from AcuDose for Patient 3. Respondent documented on the MAR that she administered Demerol 50 milligrams to Patient 3 at 8:25 p.m., which occurred before she removed the drug from AcuDose. Respondent wasted Demerol 50 milligrams at 9:29 p.m., approximately one hour after she removed the drug from AcuDose.

j. On or about July 26, 2008, at 3:06 a.m., Respondent removed Demerol 100 milligrams syringe from AcuDose for Patient 3. Respondent documented on the MAR that she administered Demerol 50 milligrams to Patient 3 at 3:02 a.m., which occurred before she removed the drug from AcuDose. Respondent failed to follow the physician's order as she allowed only five hours between administering Patient 3's Demerol, and the physician's order was for Demerol 50 milligrams IM every six hours as needed for pain.

PATIENT 4

k. On or about July 28-29, 2008, Respondent was assigned to work the night shift. Respondent was assigned to the care of Patient 4. Patient 4 had a physician's order dated July 27, 2008, for Dilaudid 1 milligram IV every two hours as needed for severe pain. Patient 4 also had a physician's order dated July 27, 2008, for Oxycodone/Oxycontin 20 milligram tablet every twelve hours. Respondent failed to follow the physician's order in that she administered Dilaudid 1 milligram more frequently than the physician's order allowed. The specifics are set forth below.

l. On or about July 28, 2008, at 8:52 p.m., Respondent removed Dilaudid 1 milligram IV from AcuDose for Patient 4. Respondent documented on the MAR that she administered Dilaudid 1 milligram at 8:45 p.m., which occurred before she removed the drug from AcuDose.

m. On or about July 28, 2008, at 8:52 p.m., Respondent removed one Oxycodone tablet from AcuDose for Patient 4. Respondent documented on the MAR that she administered one Oxycodone tablet to Patient 4 at 8:45 p.m., which occurred before she removed the drug from AcuDose.

n. On or about July 28, 2008, at 10:34 p.m., Respondent removed Dilaudid 1 milligram IV from AcuDose for Patient 4. Respondent documented on the MAR that she administered Dilaudid 1 milligram to Patient 4 at 10:25 p.m., which occurred before she removed the drug from AcuDose. This dose of Dilaudid was also administered less than two hours after Respondent last administered Dilaudid to Patient 4.

o. On or about July 29, 2008, at 12:10 a.m., Respondent removed Dilaudid 1 milligram IV from AcuDose for Patient 4. Respondent documented on the MAR that she administered

Dilaudid 1 milligram to Patient 4 at 12:01 a.m., which occurred before she removed the drug from AcuDose. This dose of Dilaudid was also administered less than two hours after Respondent last administered Dilaudid to Patient 4.

p. On or about July 29, 2008, at 2:11 a.m., Respondent removed Dilaudid 1 milligram IV from AcuDose for Patient 4. Respondent documented on the MAR that she administered Dilaudid 1 milligram IV to Patient 4 at 2:02 a.m., which occurred before she removed the drug from AcuDose.

q. On or about July 29, 2008, at 4:00 a.m., Respondent removed Dilaudid 1 milligram IV from AcuDose for Patient 4. Respondent documented on the MAR that she administered Dilaudid 1 milligram IV to Patient 4 at 3:51 a.m., which occurred before she removed the drug from AcuDose.

r. On or about July 29, 2008, at 5:40 a.m., Respondent removed Dilaudid 1 milligram IV from AcuDose for Patient 4. Respondent documented on the MAR that she administered Dilaudid 1 milligram IV to Patient 4 at 5:30 a.m., which occurred before she removed the drug from AcuDose. This dose of Dilaudid was also administered less than two hours after Respondent last administered Dilaudid to Patient 4.

s. On or about July 29, 2008, at 7:15 a.m., Respondent removed Dilaudid 1 milligram IV from AcuDose for Patient 4. Respondent documented on the MAR that she administered Dilaudid 1 milligram IV to Patient 4 at 7:05 a.m., which occurred before she removed the drug from AcuDose. This dose of Dilaudid was also administered less than two hours after Respondent last administered Dilaudid to Patient 4.

PATIENT 5

t. On or about July 26-27, 2008, Respondent was assigned to work the night shift. Respondent was assigned to care for Patient 5. Patient 5 had a physician's order dated July 18, 2008, for Morphine 2 milligrams IV every 15 minutes as needed for pain.

u. On or about July 26, 2008, at 6:42 a.m., Respondent removed Morphine 2 milligrams syringe from AcuDose for Patient 5. Respondent documented on the MAR that she administered Morphine 1 milligram at 6:33 a.m., which occurred before she removed the drug from AcuDose.

Respondent wasted Morphine 1 milligram at 7:29 a.m., approximately 40 minutes after she removed this drug from AcuDose.

v. On or about July 26, 2008, at 9:07 p.m., Respondent removed Morphine 2 milligrams syringe from AcuDose for Patient 5. Respondent documented on the MAR that she administered Morphine 1 milligram at 9:16 p.m. Respondent wasted Morphine 1 milligram at 9:24 p.m., approximately 30 minutes after she removed this drug from AcuDose.

w. On or about July 26, 2008, at 10:10 p.m., Respondent removed Morphine Sulfate 2 milligrams syringe from AcuDose for Patient 5. Respondent documented on the MAR that she administered Morphine 1 milligram at 10:05 p.m., which occurred before she removed the drug from AcuDose. Respondent wasted Morphine 1 milligram at 10:49 p.m., approximately 30 minutes after she removed this drug from AcuDose.

x. On or about July 26, 2008, at 10:26 p.m., Respondent removed Morphine 2 milligrams syringe from AcuDose for Patient 5. Respondent documented on the MAR that she administered Morphine 1 milligram at 10:22 p.m., which occurred before she removed the drug from AcuDose. Respondent wasted Morphine 1 milligram at 10:50 p.m., approximately 25 minutes after she removed this drug from AcuDose.

y. On or about July 27, 2008, at 3:13 a.m., Respondent removed Morphine 2 milligrams syringe from AcuDose for Patient 5. Respondent documented on the MAR that she administered Morphine 1 milligram at 3:09 a.m., which occurred before she removed the drug from AcuDose. Respondent wasted Morphine 1 milligram at 4:39 a.m., approximately 75 minutes after she removed this drug from AcuDose.

z. On or about July 27, 2008, at 3:30 a.m., Respondent removed Morphine 2 milligrams syringe from AcuDose for Patient 5. Respondent wasted Morphine 1 milligram at 4:40 a.m., approximately 80 minutes after she removed this drug from AcuDose. Respondent failed to document or otherwise account for the remaining Morphine 1 milligram.

aa. On or about July 27, 2008, at 4:49 a.m., Respondent removed Morphine Sulfate 2 milligrams syringe from AcuDose for Patient 5. Respondent documented on the MAR that she administered Morphine 1 milligram on the MAR at 4:32 a.m., which occurred before she

removed the drug from AcuDose. Respondent wasted Morphine 1 milligram at 5:34 a.m., approximately 45 minutes after she removed this drug from AcuDose.

PATIENT 6

bb. On or about July 28-29, 2008, Respondent was assigned to work the night shift. Respondent was assigned to care for Patient 6. Patient 6 had a physician's order dated July 28, 2008, for Dilaudid 0.5 milligrams IV every one hour as needed for pain.

cc. On or about July 28, 2008, at 11:57 p.m., Respondent removed Dilaudid 1 milligram from AcuDose for Patient 6. Respondent documented on the MAR that she administered Dilaudid 0.5 milligrams at 11:50 a.m., which occurred before she removed the drug from AcuDose. Respondent wasted Dilaudid 0.5 milligrams at 2:10 a.m., over two hours after she removed this drug from AcuDose.

dd. On or about July 29, 2008, at 4:42 a.m., Respondent removed Dilaudid 1 milligram from AcuDose for Patient 6. Respondent wasted Dilaudid 0.5 milligrams at 4:46 a.m. Respondent failed to document or otherwise account for the remaining Hydromorphone 0.5 milligrams.

PATIENT 7

ee. On or about August 5-6, 2008, Respondent was assigned to work the night shift. Respondent was assigned to care for Patient 7. Patient 7 had a physician's order dated August 5, 2008, for Dilaudid 4 milligrams IV every two hours as needed for severe pain. Respondent administered Dilaudid more frequently than ordered by the physician, as set forth below.

ff. On or about August 5, 2008, at 10:55 p.m., Respondent removed two Dilaudid 2 milligram syringes from AcuDose for Patient 7. Respondent documented on the MAR that she administered Dilaudid 4 milligrams to Patient 7 at 10:46 p.m., which occurred before she removed the drug from AcuDose.

gg. On or about August 5, 2008, at 11:42 p.m., Respondent removed two Dilaudid 2 milligram syringes from AcuDose for Patient 7. Respondent documented on the MAR that she administered Dilaudid 4 milligrams to Patient 7 at 11:33 p.m., which occurred before she removed the drug from AcuDose. Furthermore, Respondent administered this dose of Dilaudid

less than two hours after she last administered Dilaudid to Patient 7, which was more frequent than ordered by the physician.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Gross Negligence and/or Incompetence in the Practice of Nursing)
(Bus. & Prof. Code § 2761, subd. (a)(1))

20. Complainant hereby realleges the allegations contained in paragraphs 16 through 19 and each of its subparts above, and incorporates them as if fully set forth here.

21. Respondent has subjected her registered nurse license to disciplinary action under Code section 2761, subdivision (a)(1), in that she was grossly negligent or incompetent, or both, in her nursing practice. Specifically, Respondent documented administering patients the maximum amount of pain medications allowed by the physician's orders, and at times she administered medications sooner than at the prescribed intervals, she had a pattern of removing from AcuDose much larger quantities of medications for patients in her care compared to other nurses that cared for the same patients before and after Respondent, the intervals between the times Respondent removed narcotics from AcuDose and the time she documented wastes in AcuDose sometimes exceeded 30 to 120 minutes, she failed to document or otherwise account for all medication she removed from AcuDose, she made inconsistent and unintelligible entries in hospital, patient, or other records pertaining to controlled substances, and she activated a patient's without authorization. The circumstances are more specifically set forth above in paragraphs 16 through 19.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Falsify or Make Grossly Incorrect, Inconsistent, or Unintelligible Entries in Hospital, Patient, or Other Records)
(Bus. & Prof. Code §§ 2761, subd. (a), 2762, subd. (e))

22. Complainant hereby realleges the allegations contained in paragraphs 16 through 19 and each of its subparts above, and incorporates them as if fully set forth here.

23. Respondent has subjected her registered nurse license to disciplinary action under Code sections 2761, subdivision (a), and 2762, subdivision (e), in that she repeatedly made grossly inconsistent or unintelligible entries in hospital, patient, or other records pertaining to

controlled substances. The circumstances are set forth above in paragraphs 16 through 19 and each of its subparts.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters alleged in this Accusation, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 691632, issued to Jennifer Paige Kline, also known as Jennifer P. Rohn, also known as Jennifer Rohn Sovohn, also known as Jennifer Hutchins;

2. Ordering Jennifer Paige Kline, also known as Jennifer P. Rohn, also known as Jennifer Rohn Sovohn, also known as Jennifer Hutchins to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: July 11, 2011

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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